ENROLLMENT FORM
(District of Columbia Groups)

CareFirst BlueCross BlueShield

Group Hospitalization and Medical Services, Inc.
840 First Street, NE • Washington, DC 20065

1 EMPLOYER INFORMATION: To be completed by the employer.

Employer/Group Administrator

Group Number:

Medical: _____

Effective Date Requested __ __/__ __/__ __

Check all that apply

Employment Status ☐ Active ☐ Full Time ☐ Part Time ☐ Retired

2 TYPE OF REQUEST

☐ New Subscriber ☐ Coverage Change ☐ Add Dependents ☐ Delete Dependents

☐ Any information change (name or address change)

Are you enrolling eligible dependents?

☐ Yes ☐ No

3 SUBSCRIBER INFORMATION

Social Security Number __ __ __ - __ __ - __ __ __ __

Subscriber Last Name | First Name | Middle Initial

Date of Birth __ __/__ __/__ __

Sex: ☐ Male ☐ Female

Date of Hire: __ __/__ __/__ __

Status: ☐ Single ☐ Married/Partner ☐ Other ☐ Legally Separated ☐ Divorced

Effective Date of Status __ __/__ __/__ __

Street Address | Apt. | City | County | State

Country | Zip

Home Phone ( ) __ __ __ - __ __ __ __

Work Phone ( ) __ __ __ - __ __ __ __

4 CHANGE TO EXISTING COVERAGE

Dependents affected by adds or deletes must be listed in Section 5 Dependent Information.

Identification Number, if different from Social Security Number _____

☐ *ADD* dependent(s) listed in Section 5

☐ *ADD* spouse due to marriage on _____ (Date)

☐ *ADD* partner on _____ (Date)

☐ *ADD* child due to **adoption** on _____ (Date) or appointed **legal guardian** by court decree dated _____ .
(Note: Documentation of adoption or court-appointed legal guardianship must be provided. CareFirst BlueCross BlueShield will pay the cost of the documentation required to provide proof of adoption or court-appointed legal guardianship.)

☐ *REMOVE* dependent(s) listed in Section 5 due to _____ (Reason)_____ (Date)

☐ *CHANGE* address to that shown in Section 3 above

☐ *CHANGE* my name from _____ to that shown in Section 3

5 SUBSCRIBER & DEPENDENT INFORMATION: Please list all persons to be covered.

COVERAGE LEVEL – Please confirm with your employer the details of the benefit options and coverage levels offered by your employer prior to completing this section to avoid delays in processing this Enrollment Form.

COVERAGE LEVELS OF SUBSCRIBER AND DEPENDENTS, IF APPLICABLE

☐ Individual

☐ Family

☐ Coverage Complementary to Medicare (Individual Only)

SUBSCRIBER INFORMATION

Last	First	MI	Coverage Level	Relationship	Sex	Date of Birth	Social Security Number
			☐ Medical	Subscriber			

5 SUBSCRIBER & DEPENDENT INFORMATION (continued)

DEPENDENT INFORMATION: If the subscriber has more than four dependents, please list the additional dependents on a separate Enrollment Form.

Last	First	MI	Coverage Level	Relationship	Sex	Date of Birth	Social Security Number
			☐ Medical				
			☐ Medical				
			☐ Medical				
			☐ Medical				

Is anyone listed above a student or disabled? ☐ YES ☐ NO

If the answer is YES, please list the name of the person _____

If a full-time student, please attach student certification form. If yes, disabled, please attach disability certification form and supporting documentation.

6 MEDICARE INFORMATION: To be completed if applicable.

		Medicare Number	Hosp. Eff. Date (Part A)	Med. Eff. Date (Part B)
Are You Eligible for Medicare?	☐ Yes ☐ No	If Yes: _ _ _ - _ _ _ - _ _ _ _ - _ _	_ _ / _ _ / _ _	_ _ / _ _ / _ _
Reason for Entitlement:	☐ Age 65 or older	☐ End Stage Renal Disease	☐ Disabled	
Spouse/Partner	☐ Yes ☐ No	If Yes: _ _ _ - _ _ _ - _ _ _ _ - _ _	_ _ / _ _ / _ _	_ _ / _ _ / _ _
Reason for Entitlement:	☐ Age 65 or older	☐ End Stage Renal Disease	☐ Disabled	
Child/Dependent?	☐ Yes ☐ No	If Yes: _ _ _ - _ _ _ - _ _ _ _ - _ _	_ _ / _ _ / _ _	_ _ / _ _ / _ _
Reason for Entitlement:	☐ Age 65 or older	☐ End Stage Renal Disease	☐ Disabled	

7 OTHER HEALTH INSURANCE INFORMATION

IF YOU HAVE OTHER HEALTH INSURANCE COVERAGE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED.

Is any person listed on the Enrollment Form covered by another health care plan, HMO, or Medicare? ☐ Yes ☐ No

If yes, will this coverage be continued? ☐ Yes ☐ No If no, please provide the cancellation date _ _ / _ _ / _ _

Policyholder's Name	Phone Number of Other Insurer	Date of Birth
	( ) _ _ _ - _ _ _ _	_ _ / _ _ / _ _

Name and Address of Insurance Company

Policy Number	Termination Date	Effective Date of Policy
	_ _ / _ _ / _ _	_ _ / _ _ / _ _

Services Covered: ☐ Hospital Services ☐ Physician Services ☐ Major Medical ☐ Drug Program

☐ Dental Services ☐ Eye/Vision Care Services ☐ HMO ☐ Mental Illness Services

Does this policy cover you? ☐ Yes ☐ No Your spouse? ☐ Yes ☐ No Your children? ☐ Yes ☐ No

Please list name(s) of children covered _____

Is this coverage under COBRA? ☐ Yes ☐ No If yes, reason for cancellation _____

_____ Cancellation Date _ _ / _ _ / _ _

I hereby apply, on behalf of myself and each dependent listed above for the health coverage indicated. If this Form is accepted, coverage will be provided according to the terms and conditions of the contract between CareFirst BlueCross BlueShield and my employer. I agree to be bound by that contract. If subscription charges are required by my employer, I agree to pay current and future subscription charges to my employer.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

I have carefully read this Form and agree to its terms. The recorded answers on this Form are, to the best of my knowledge and belief, full, complete and true as of this date.

THIS INFORMATION IS SUBJECT TO VERIFICATION. FAILURE TO COMPLETE ANY SECTION MAY DELAY CLAIMS PAYMENT.

_____ __/__/__ _____ __/__/__
Subscriber's Signature Date Dependent's Signature Date

_____ __/__/__
Authorization Signature Date